STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 12/16/24 to 12/23/24 Census: 128 Sample: 25 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to: a.) follow a physician's order and b.) adhere to professional standards of nursing practice during the medication administration observation. This deficient practice was identified for 2 of 2 nurses who administered medications to 2 residents (Residents #34 and #49) on 2 of 4 nursing units (Court [redacted] and Court [redacted]) and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered	F 658	1. A. Resident #34 had NJ Exec Order 26.4b1 [redacted] as a result of the deficient practice of nurses not following physician's order to remove NJ Exec Order 26.4b1 [redacted] after the ordered duration (12-hour after placement). The NJ Exec Orde was removed and NJ Exec O assessed with no NJ Exec Order 26.4b noted and replaced with the ordered NJ Exec Orde on NJ Exec Order 26.4b1 The order was clarified and updated to reflect correct removal time. B. Resident #49 had NJ Exec Order 26.4b1 [redacted] as a result of the deficient practice of not retaking a NJ Exec Order 26.4b1 after initially getting a NJ Exec Order 26.4b1 NJ Exec Order 2 [redacted] and administering the	1/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/02/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1.) On 12/17/24 at 8:30 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 as she prepared medications to be administered to Resident #34, which included a NJ Exec Order 26.4b1 [redacted] (NJ Exec Order 26.4b1 to be applied to the resident's NJ Exec Order 26.4b1. At 8:49 AM, LPN #1 informed Resident #34 that she had to remove his/her NJ Exec Order 26.4b1 before she applied another patch. She proceeded to pull back the resident's blanket and removed a NJ Exec Order 26.4b1 from the resident's NJ Exec Order 26.4b before she applied the scheduled NJ Exec Order 26.4b1 At 8:53 AM, LPN #1 reviewed the order for NJ Exec Order 26.4b1 with the surveyor and stated	F 658	medication without consulting the physician regarding the concern. Resident's doctor was notified and assessed Resident #49 and there were no new recommendations. 2. A. All residents with lidocaine patch orders have the potential to be affected by this deficient practice of nurses not following physician's order to remove lidocaine patch after the ordered duration (12-hour after placement). B. All residents with blood pressure medications could be affected by the deficient practice of not retaking a blood pressure after initially getting a low diastolic blood pressure and administering the medication without consulting the physician regarding the concern. 3. A. On 12/20/2024, A one-on-one in-service was completed by the Assistant Director of Nursing with LPN#1 who was responsible for resident #34's NJ Exec Order 26.4b1 [redacted] in question on transcription policy and removal of NJ Exec Order [redacted] as ordered. Additionally, all nurses received education by the Assistant Director of Nurses on the policy and procedure for following physician orders for [redacted] including removal and transcription. An audit was conducted for NJ Exec Order 26.4b1 orders to ensure proper order transcription. No further issues identified. B. On 12/20/2024, A one-on-one in-service was completed by the Assistant Director of Nursing with LPN#2 who was	

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F 658	Continued From page 2 that the order specified that the [redacted] was ordered to be removed at bedtime (HS). LPN #1 further stated, the evening shift nurses were supposed to take it off last night ([redacted]). A review of Resident #34's Order Recap Report (ORR) revealed a physician's order (PO) dated [redacted], for a [redacted] apply to [redacted] topically one time a day for [redacted] remove at bedtime, and remove per schedule. A review of Resident #34's Medication Administration Record (MAR) revealed an order for [redacted]) apply to [redacted] one time a day for [redacted] remove at bedtime, and remove per schedule which had a start date of [redacted] and was scheduled to apply at 9:00 AM, and remove at 8:59 AM, rather than at 9:00 PM, or bedtime. Further review of the MAR revealed that the order was amended to include a removal time at [redacted], and the order was then discontinued. Further review of Resident #34's MAR revealed an order for [redacted]) apply to [redacted] one time a day for [redacted] remove at bedtime and remove per schedule with a start date of [redacted] that was scheduled to be applied at 9:00 AM and removed at 9:00 PM, after surveyor inquiry. On 12/17/23 at 10:23 AM, the surveyor interviewed [redacted] who stated that if there was an order to remove a [redacted] at night they are supposed to take it off at night as ordered. LPN/UM #1 stated that she believed that	F 658	responsible for resident #49's medication administration on holding medication and seeking physician consultation when vital signs results show [redacted]. Additionally, all nurses received education by the Assistant Director of Nurses on the policy to hold medication and seek physician consultation when vital signs results show [redacted]. 4. The Director of Nurses, Assistant Director of Nurses and Unit managers will audit new orders for lidocaine patches weekly for 4 weeks and monthly for 2 months to ensure all resident lidocaine orders are transcribed properly and followed. The Director of Nurses, Assistant Director of Nurses and Unit Managers will audit med pass weekly for 4 weeks and monthly for two months to ensure any concerning vital sign results are communicated to the Physician for consultation prior to administration of medication. The results of these audits will be reported to the QAPI committee monthly for 3 months.	

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F 658	Continued From page 3	F 658		

most had orders to remove it. LPN/UM #1 further stated that she was always told by the pharmacy that it was not effective anymore if it were left on longer than the prescribed time.

On 12/18/24 at 1:09 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that a NJ Exec Order 26.4b1 was only good for 12 hours and would not be beneficial if it were left on for more than 12 hours. The U.S. FOIA (b) stated that the expectation was for the NJ Exec Order 26.4b1 to be removed at HS as it was ordered.

On 12/18/24 at 1:38 PM, the US FOIA (b)(6) in the presence of another surveyor and the U.S. FOIA (b), was informed of the facility's failure to follow Resident #34's order for NJ Ex Order 26.4b1 and properly schedule the application and removal of the medication as it were ordered.

On 12/19/24 at 9:18 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that an order for NJ Exec Order 26.4b1 should be removed at HS as ordered. The US FOIA (b)(6) stated that it should have been taken off because you have to follow the order.

On 12/20/24 at 9:22 AM, the surveyor interviewed the U.S. FOIA (b) who stated that it was determined that the nurse had a transcription error when the physician's order for NJ Exec Order 26.4b1 was entered into the electronic health record (EHR). The U.S. FOIA (b) stated that the order was scheduled for removal at 8:59 AM, and should have been scheduled at 9:00 PM, so it did not show up on the MAR for the evening shift to remove it. The U.S. FOIA (b) further stated that neither the Consultant

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F 658	Continued From page 4 Pharmacy review or the 24 Hour chart check noticed that the wrong time was entered into the MAR for removal. 2.) On 12/17/24 at 9:37 AM, the surveyor observed Resident #49 who was seated in a chair in their room. LPN #2 entered the resident's room with permission and used an automated (electronic) NJ Exec Order 26.4b1 machine to obtain the resident's NJ Exec Order 26.4b1 LPN #2 stated that the resident's was and the was (the American Heart Association (AHA) recommends a target below of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) and (NJ Exec Order 26.4b1 and defined NJ Exec Order 26.4b1) as a of At 9:40 AM, LPN #2 checked the resident's medication orders in the electronic health record (EHR) and noted that the resident was scheduled to receive NJ Exec Order 26.4b1 (NJ Exec Order 26.4b1 NJ Exec Order 26.4b1). LPN #2 stated that there were no parameters (guidelines on when to hold or administer a medication based on numerical values of the NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 or LPN #2 hesitated on whether or not to administer the medications based on the resident's reading of LPN #2 then instructed the resident to take the medications without first rechecking the to confirm accuracy or notifying the physician to relay the concern. When interviewed at that time, LPN #2 stated that she was definitely going to let the physician know	F 658		

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F 658	Continued From page 5	F 658		

and see if he wanted parameters added to the medication's orders. When the surveyor asked LPN #2 if she should have let the doctor know of her concerns with the resident's [redacted] value before or after medication administration, LPN #2 stated that since the resident did not show any signs or symptoms of distress she had waited until after the mediation was already administered to notify the physician.

A review of the resident's Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [redacted]

A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted] included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident's [redacted].

A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated [redacted], of resident has [redacted]. Interventions included: Give all [redacted] medications as ordered. Monitor for side effects such as [redacted] and [redacted]) and effectiveness. Obtain [redacted] readings as ordered. Take [redacted] readings under the same conditions each time.

A review of the Order Summary Report (OSR) included the following physician's orders PO:

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F 658	Continued From page 6 A PO, dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1) Give by every related to NJ Exec Order 26.4b1 . Administer on NJ Exec Order 26.4b1 days. A PO, dated NJ Exec Order 2, for NJ Exec Order 26.4b1 Give NJ Exec Order 26.4b1 for NJ Exec Order 26 related to primary NJ Exec Order 26.4b1 On 12/17/24 at 10:07 AM, the surveyor interviewed LPN/UM #1 who stated that she would have expected for the nurse to recheck the resident's NJ Exec Order 26.4b1 and if it were still NJ Exec O hold the medication and call the doctor. LPN/UM #1 stated that the issue would be with a NJ Exec Order 2 NJ Exec Order 26.4b1 o NJ Exec Order 26.4b1 could drop even more. LPN/UM #1 further stated that if you made a nursing judgement to check a NJ Exec Order 26.4b1 , she would expect the nurse to check the order and follow it all of the way through. On 12/18/24 at 11:09 AM, the surveyor interviewed the U.S. FOIA (b) who stated that if a resident had a U.S. FOIA (b)(6), she would recheck the NJ Exec Orde to make sure that it was accurate. The U.S. FOIA (b) stated that she would not have given the medication until she called the physician because the NJ Exec O was already low and the medication could lower the NJ Exec even more. A review of the resident's NJ Exec Order 26.4b and Vitals Summary revealed that the resident's last documented NJ Exec Order 26.4b1 reading was on NJ Exec Order 26.4b1 was NJ Exec Order 26.4 Further review of the NJ Exec Order 26.4b and Vitals Summary revealed that the resident's NJ Exec Order 26.4b NJ Exec Orde	F 658		

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F 658	Continued From page 7 NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 NJ Exec Ord only dropped below NJ Exec on NJ Exec Order 26.4b1) and NJ Exec Order 26.4b1 A review of the Progress Notes (PN) included a Nursing Progress Note (NPN), dated NJ Exec Order 26.4b1 at NJ Exec Order 26.4b1 which included, the physician was notified of the NJ Exec Order 26.4b1 was less than NJ Exe on NJ Exec Orde and stated that he was okay to administer the NJ Exec medication. Further review indicated the resident remained stable during the shift with NJ Exec Order 26.4b1 The physician was notified after surveyor inquiry. On 12/18/24 at 1:38 PM, in the presence of another surveyor and the U.S. FOIA (b), the surveyor informed the U.S. FOIA (b)(6) of concerns that were identified during the Medication Observation. On 12/19/24 at 1:04 PM, the surveyor interviewed the US FOIA (b)(6) who stated that the nurse should have called the physician first before she administered the NJ Exec Order 26.4b1 medication. The U.S. FOIA (b)(6) further stated that, "you should recheck the NJ Exec Order 26.4b1 to ensure that it was not off and alert the doctor to make extra sure because it was NJ Exec Order 26.4b1 A review of the facility's "Administering Medications" policy reviewed/revised February 2024, included: Medications shall be administered safely and timely, as prescribed. Medications must be administered in accordance with the orders, including any required time frame.....If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident	F 658		

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F 658	Continued From page 8 or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns.....The following information must be checked/verified for each resident prior to administering mediations...Vital signs, if necessary, per physician's order... NJAC 8:39-29.2(d)	F 658		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		1/17/25

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F 755	Continued From page 9 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to ensure that all Drug Enforcement Administration (DEA) 222 forms were completed with sufficient detail to enable accurate accountability and reconciliation for controlled medications. This deficient practice was identified for 6 of 6 DEA 222 forms reviewed in 1 of 1 back up controlled medication storage area and was evidenced by the following: On 12/17/24 at 1:01 PM, the surveyor reviewed the facility's DEA-222 records for the back up controlled medication storage and noted that on 8/15/24, 9/4/24, 9/30/24, 11/1/24, 11/27/24, and 12/16/24, Part 5 of the forms that were required to be filled in by the purchaser failed to include the number of controlled medications received by the facility and the date that they were received. On 12/18/24 at 11:22 AM, the surveyor interviewed the U.S. FOIA (b)(6)) regarding the DEA 222 Forms. The U.S. FOIA (b) stated that she did not know that she was supposed to fill in Part 5 of the DEA-222 form which indicated that it was to be filled in by the Purchaser. When the surveyor asked the U.S. FOIA (b) why she had not filled in Part 5 of the DEA 222 Form she stated,	F 755	1. No resident had a negative outcome due to the deficient practice of incomplete 222 forms section 5. On 12/20/2024, US FOIA (b)(6) received 1:1 education by the Regional Director of Nursing on importance of completing section 5 of the 222 form and attaching packing slip when medication is received. 2. All residents on narcotic medication have the potential to be affected by the deficient practice. Section 5 of the 222 forms were reviewed to ensure completion. 3. On 12/20/2024, the Regional Director of Nursing educated the US FOIA (b)(6) on the importance of completing section 5 of the 222 forms. In addition, new process was implemented where pharmacy consultant will audit 222 forms on monthly basis. 4. The Director of Nursing will audit 222 forms weekly for 4 weeks, and then monthly for 2 months. Results of these audits will be reported to the QAPI Committee monthly for 3 months.	

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F 755	Continued From page 10 "no one, not even the pharmacy, ever told me that." The surveyor reviewed the instructions with the [redacted] that were printed on the back of the form and she stated that she had not read the instructions. The [redacted] stated that someone showed her how to complete the form previously and she followed their instructions. On 12/18/24 at 11:40 AM, the surveyor interviewed the [redacted] of the facility's pharmacy provider, who stated that the process was for the DEA-222 forms to be filled in completely by the purchaser, or nursing home. The [redacted] stated that the form was highlighted and specified which section of the forms needed to be completed by the purchaser. The [redacted] stated that Part 5 had to be dated and had to specify the number of controlled medications received upon delivery. The [redacted] stated that the [redacted]) was responsible to ensure that Part 5 was filled in as the purchaser because a valid DEA Number was needed. On 12/18/24 at 12:06 PM, the surveyor interviewed the [redacted] who stated that he only signed the DEA 222 Forms and filled out his DEA number and the [redacted] completed the form and sent it out to the pharmacy. The [redacted] stated he had never seen any medications delivered to the facility. The [redacted] stated that when the facility received the shipment from the pharmacy, nursing was supposed to count the amount of controlled medications received and put them in a secured box. The [redacted] stated the process was like that everywhere. On 12/18/24 at 1:09 PM, the surveyor conducted	F 755		

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F 755	Continued From page 11 a telephone interview with the U.S. FOIA (b)(6) who stated the U.S. FOIA (b) or the person who received the delivery of the controlled medications were responsible to document the quantity received and the date they received it under Part 5. The U.S. FOIA (b)(6) stated that the U.S. FOIA should review but the U.S. FOIA (b), or nursing department, was confirming the quantity received. When the surveyor asked why it was important to completed Part 5 of the DEA 222 form the U.S. FOIA (b)(6) stated, "you want to make sure the quantity is right and it is a Board of Pharmacy Regulation for Part 5 of the DEA-222 completion." The U.S. FOIA (b)(6) stated that it was mandatory to fill in Part 5 of the DEA-222 form. At that time, the U.S. FOIA (b)(6) stated that there were directions or on the back of the form which instructed to fill in Part 5 and indicated that it were to be completed by the receiver. The U.S. FOIA (b)(6) stated that the assigned U.S. FOIA (b)(6)) who came into the facility on a quarterly basis checked to see if it were done. The U.S. FOIA (b)(6) further stated that the DEA-222 forms would have been checked by the U.S. FC, but he was not sure when. On 12/18/24 at 1:38 PM, in the presence of another surveyor and the U.S. FOIA (b), the U.S. FOIA (b)(6) was informed that the facility failed to completed Part 5 on six out of six DEA-222 forms. On 12/19/24 at 9:16 AM, during a follow-up interview the U.S. FOIA (b)(6) stated that the assigned U.S. FC, who was not available for an interview, had not checked the DEA-222 forms but he should have.	F 755		

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	315280	A. BUILDING _____ B. WING _____	12/23/2024

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F 755	Continued From page 12 A review of the facility's undated "DEA 222 Completion" policy included: Completed Required Sections #1-6.....Number of items and Date Received: Once the order is received, complete the number of items and date they were received on your photocopy. You must retain a copy of this form for your records and auditing purposes...	F 755		
F 880 SS=D	NJAC- 8:39-29.7 (C) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		1/17/25

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F 880	Continued From page 13 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 14 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to adhere to proper infection control practices during the medication administration observation. This deficient practice was identified for 1 of 2 nurses on 1 of 2 units (Court NJ Exec Orde observed for medication administration and was evidenced by the following: On 12/17/24 at 8:59 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 as she prepared medications for Resident #33. LPN #1 donned (applied) gloves and obtained the resident's NJ Exec Order 26.4b1 LPN #1 then doffed (removed) her gloves before she returned to the computer to review the resident's physcians orders (PO) before she administered the medications to the resident. LPN #1 then proceeded to wash her hands for 15 seconds. LPN #1 stated that there was no paper towels available to dry her hands. LPN #1 then proceeded to turn the faucet off with her bare hands. LPN #1 returned to the medication cart and obtained a tissue to dry her hands. LPN #1 failed to sanitize her hands after she dried them. On 12/17/24 at 9:27 AM, LPN #1 then pushed the medication cart and NJ Exec Order 26.4b1 machine over to the outside of Resident #49's room. LPN #1 then proceeded to prepare the resident's medications without first performing hand hygiene. LPN #1 stated that the resident was on NJ Exec Order 26.4b1 [redacted]) before she donned a gown, gloves, and mask without	F 880	1. Resident #33 and resident #49 had NJ Exe [redacted] as a result of the deficient practice of; a. LPN #1 who failed to properly perform hand hygiene after removing gloves. b. LPN #1 who failed to clean a NJ Exec Orde [redacted] cuff between residents On 12/17/2024, Assistant Director of Nursing completed 1:1 education with LPN #1 on hand hygiene and disinfecting NJ Exec Order 26.4b1 cuff between residents. 2. All residents have the potential to be affected by these deficient practices. 3. On 12/17/2024, Infection Preventionist completed one on one education with LPN #1 on hand hygiene and proper infection prevention when donning and doffing Personal Protective Equipment (PPE) and disinfecting equipment between residents. Competency on hand hygiene was completed with nurse with satisfactory return demonstration. Additionally, education was initiated for all nurses on Hand Hygiene and proper infection prevention when donning and doffing PPE and disinfecting equipment between residents. Rounds and observations were completed to ensure staff were using proper hand hygiene when donning and doffing PPE and proper disinfecting of BP cuffs between residents 4. Infection Preventionist will complete rounds weekly for 12 weeks to ensure all staff perform hand hygiene on proper infection prevention when donning and doffing PPE and disinfecting equipment between residents. The results of these audits will be reported to the QAPI	

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F 880	Continued From page 15 first performing hand hygiene. LPN #1 then entered the resident's room and obtained the resident's [redacted] without first cleaning the [redacted] cuff. LPN #1 then doffed her gown and gloves and washed her hands in the resident's bathroom. On 12/17/24 at 9:58 AM, LPN #1 brought the [redacted] machine out into the hallway. When interviewed, LPN #1 stated that she should have used hand sanitizer after she turned the faucet off with her bare hands because there was a risk of spreading germs. When the surveyor asked LPN #1 what the process was for sanitizing the [redacted] cuff and machine, she stated that she planned to clean it after she used it for Resident #49 because the resident was on [redacted] LPN #1 stated that she did not typically clean it between residents but because the resident was on [redacted] she would clean it. LPN #1 further stated that if the [redacted] cuff and machine were not cleaned between residents there was a potential to spread germs. On 12/17/24 at 10:23 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that LPN #1 should have washed her hands after she touched the faucet for infection control standards of practice. LPN/UM #1 stated that the nurses were supposed to wipe down the [redacted] machine with disinfectant wipes before the shift and between each resident for infection control purposes. On 12/18/24 at 10:47 AM, the surveyor interviewed the [redacted] who stated that LPN #1 could have used a tissue product, though not effective, to shut off the water and	F 880	committee monthly for 3 months.	

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F 880	Continued From page 16 then used hand sanitizer to clean her hands as a precautionary measure to kill bacteria on her hands. The [U.S. FOIA (b)(6)] stated that LPN #1 should have stopped and cleaned her hands between residents and rooms to reduce the spread of infection so that she did not bring any bacteria from one room to another. The [U.S. FOIA (b)(6)] further stated the [NJ Exec Order 26.4b1] cuff should have been cleaned with a disinfectant wipe between each resident or a bleach wipe if it were used in an isolation room. The [U.S. FOIA (b)(6)] stated that they were not taking the proper infection control steps if the [NJ Exec Order 26.4b1] machine were not cleaned between residents. On 12/18/24 at 11:09 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated that she would have walked into another bathroom and washed her hands and used hand sanitizer if there were no paper towels in the restroom. The [U.S. FOIA (b)(6)] stated that it could have been an infection control issue because LPN #1 turned off the faucet with her hands. The [U.S. FOIA (b)] further stated they have to disinfectant the [NJ Exec Order] cuff with an antibacterial wipe between each patient. The [U.S. FOIA (b)] stated that a failure to clean the [NJ Exec Order 26.4b1] cuff could also be an infection control issue. On 12/18/24 at 1:38 PM, in the presence of another surveyor and the [U.S. FOIA (b)], the [U.S. FOIA (b)(6)] was informed of the infection control concerns that were identified during the medication administration observation. A review of the facility's "Handwashing/Hand	F 880		

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F 880	Continued From page 17 Hygiene" policy reviewed/revised April 2024, included: "The facility considers hand hygiene the primary means toprevent the spread of infections....All personnel shall follow the Handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors...Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:...Before and after direct contact with residents; Before preparing or handling mediations;.....After contact with a resident's intact skin;...After removing gloves;.....Before and after entering isolation precaution settings." A review of the facility's "Cleaning of Non-Critical, Reusable Resident Care Equipment" policy reviewed/revised January 24 included:...Reusable patient care equipment will be cleaned, disinfected, and/or reprocessed before reuse with another patient or before being placed in storage... NJAC 8:39-19.4	F 880		

New Jersey Department of Health

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey, for 2 of 2 weeks of staffing prior to the recertification survey dated 12/23/24. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	1. No residents were affected by not meeting the State of NJ minimum staffing requirements as determined by routine monitoring and review on those dates that no significant changes were noted. 2. All residents could be affected by not meeting State of NJ minimum staffing requirements. 3. Recruitment and retention efforts continue to include: a. Job fairs b. Daily staffing meetings and weekly Regional Labor Management reviews c. Training mentor program to support retention d. Culture committee to improve and	1/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/02/25

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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to survey from 12/01/2024 to 12/14/2024, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -12/01/24 had 10 CNAs for 128 residents on the day shift, required at least 16 CNAs. -12/02/24 had 10 CNAs for 128 residents on the day shift, required at least 16 CNAs. -12/03/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -12/05/24 had 15 CNAs for 126 residents on the day shift, required at least 16 CNAs. -12/08/24 had 12 CNAs for 126 residents on the day shift, required at least 16 CNAs. -12/11/24 had 14 CNAs for 128 residents on the day shift, required at least 16 CNAs.	S 560	maintain staff morale 5. Recruitment bonus and sign-on bonuses offered. 6. Completive wage analysis 7. Hired Elite Recruiting to support increased recruiting of nurses and aides 8. Weekend warrior program started 4. To monitor and maintain ongoing compliance the Director of Nursing or designee will monitor staffing daily for 1 week, weekly for 3 weeks and monthly for 3 months. Results will be presented to the Quality Assurance and Performance Improvement team monthly for continued review and recommendations until substantial compliance is maintained.	

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S 560	Continued From page 2 On 12/20/24 at 9:07 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one direct care staff for 10 residents on the 3:00 PM - 11:00 PM shift, and one direct care staff for 14 residents on the 11:00 PM - 7:00 AM shift. On 12/20/24 at 9:14 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one direct care staff for 10 residents on the 3:00 PM - 11:00 PM shift, and one direct care staff for 14 residents on the 11:00 PM - 7:00 AM shift. A review of the facility's "Staffing" policy, revised June 2024, included, "The facility will meet all federal, state, and local staffing requirements," and, "Staffing ratios will be reviewed and adjusted based on the acuity and care needs of residents, ensuring that there are enough licensed and unlicensed personnel to provide high-quality care." Further review of the policy included, "The facility will maintain a minimum of staff-to-resident ratio of 1:8 during daytime shifts, 1:10 during evening shifts, and 1:14 during night shifts."	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required	S1680		1/17/25

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S1680	Continued From page 3 at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

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S1680	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of the Nurse Staffing Reports for the weeks from 12/01/2024 to 12/14/2024, it was determined that the facility failed to provide at least minimum staffing levels for 1 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 12/01/2024 Required Staffing Hours: 379.25 -12/01/24 had 360 actual staffing hours, for a difference of -19.25 hours. On 12/20/24 at 9:14 AM, the surveyor interviewed the Director of Nursing (DON) who stated the facility's staffing was determined by the New Jersey minimum requirements for staffing and the residents' acuity. The DON further stated that "sometimes" the facility had days with low staffing, but was unsure the reason.	S1680	1. No residents were affected by not meeting the State of NJ minimum staffing requirements as determined by routine monitoring and review on those dates that no significant changes were noted. 2. All residents could be affected by not meeting State of NJ minimum staffing requirements. 3. Recruitment and retention efforts continue to include: a. Job fairs b. Daily staffing meetings and weekly Regional Labor Management reviews c. Training mentor program to support retention d. Culture committee to improve and maintain staff morale 5. Recruitment bonus and sign-on bonuses offered. 6. Completive wage analysis 7. Hired Elite Recruiting to support	

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S1680	Continued From page 5 A review of the facility's "Staffing" policy, revised June 2024, included, "The facility will meet all federal, state, and local staffing requirements," and, "Staffing ratios will be reviewed and adjusted based on the acuity and care needs of residents, ensuring that there are enough licensed and unlicensed personnel to provide high-quality care." Further review of the policy included, "Adjustments to staffing will be made based on: -Resident acuity levels -Special care units -Fluctuations in resident census."	S1680	increased recruiting of nurses and aides 8. Weekend warrior program started 4. To monitor and maintain ongoing compliance the Director of Nursing or designee will monitor staffing daily for 1 week, weekly for 3 weeks and monthly for 3 months. Results will be presented to the Quality Assurance and Performance Improvement team monthly for continued review and recommendations until substantial compliance is maintained.	
S2310	8:39-31.6(h) Mandatory Physical Environment Copies of the emergency operations plan shall be sent to municipal and county emergency management officials for their review. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility provided documentation on 12/16/2024, 12/17/2024 and 12/18/2024 in the presence of facility management, it was determined that the facility failed to send a copy of their Emergency Preparedness Plan (EPP) to the Camden County Office Emergency management (CCOEM) and Local Office Emergency Management (LOEM) officials for review. This deficient practice had the potential to affect all 132 residents and was evidenced by the following:	S2310	1. No residents were affected by deficient practice of failing to send a copy of the facility Emergency Preparedness Plan to the County Office of Emergency Management. On 12/18/2024, an email request was sent to the County Office of Emergency Management to schedule a review of the facility's Emergency Management Plan. 2. All residents could be affected by deficient practice of failing to send a copy of the facility Emergency Preparedness	1/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060407	A. BUILDING: _____ B. WING _____	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S2310	Continued From page 6 A review of the EPP book on 12/18/2024 at approximately 8:45 AM, revealed there was no evidence that their EPP book was sent to the CCOEM and LOEM. In an interview, a request was made to the Administrator for evidence of the EPP book being sent to the CCOEM and LOEM from 1/01/2023 through 12/16/2024. The facility was unable to provide any additional information. On 12/18/2024 at approximately 1:34 PM, the Administrator and Maintenance Director were informed of the deficient practice during the Life Safety survey exit. NJAC 8:39 -31.6 (h)	S2310	Plan to the County Office of Emergency Management. 3. On 12/18/2024, a 1:1 education was completed by the Regional Plant Operations Manager with the US FOIA (b)(6) [redacted] on the requirement to request an annual review of the facility's Emergency Preparedness Plan. 4. To monitor and maintain ongoing compliance the Administrator and Regional Director of Plant Operations will review the facility's Emergency Preparedness Plan annually and ensure the Director of Maintenance requests review by the County Office of Emergency Management. The review and request to the County Office of Emergency Management will be presented to the Quality Assurance and Performance Improvement team annually to ensure compliance is maintained.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315280	A. Building B. Wing	1/22/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 01/17/2025	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 01/17/2025	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 01/17/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/23/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060407 Y1	A. Building B. Wing Y2	1/22/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/17/2025	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 01/17/2025	ID Prefix S2310 Reg. # 8:39-31.6(h) LSC	Correction Completed 01/17/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/23/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	**12/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	**1417 BRACE ROAD** **CHERRY HILL, NJ 08034**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Silver Healthcare Nursing Home was in compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/16/2024, 12/17/2024 and 12/18/2024, and Silver Healthcare Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This building was identified as the "Atrium Building" (#1) and is a single-story building, Type V protected construction. The Atrium Building #1 has 38 Resident sleeping rooms with common areas that Residents, Visitors and Staff could use. The census in the Atrium Building #1 was 0 at the time of survey. The building is divided into 3 smoke zones. The total census of the 3 buildings was 128 at the time of the survey. This deficiennt practice was identified in 1 of 3 buildings and was evidenced by the following,	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/02/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	**12/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	**1417 BRACE ROAD** **CHERRY HILL, NJ 08034**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Survey and Field Operations on 12/16/2024, 12/17/2024 and 12/18/2024, and Silver Healthcare Center was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This building was identified as the "Pavilion Building" (#2) and is a single-story building, Type V protected construction. The Pavilion Building #2 has 22 Resident sleeping rooms with common areas that Residents, Visitors and Staff could use. The total census of the 3 buildings was 128 at the time of the survey. The building is divided into 3 smoke zones.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/16/2024, 12/17/2024 and 12/18/2024, and Silver Healthcare Center was found to be in ncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This building was identified as the "Court Building" (#3) and is a Two-story building, Type II protected construction. The Court Building #3 is made up of Court #1 (first floor) which has 37 Resident sleeping rooms and common areas and	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	**12/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	**1417 BRACE ROAD** **CHERRY HILL, NJ 08034**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 Court #2 (second floor) which has 33 Resident sleeping rooms. There is a "Vent Unit" on the second floor with 8 Resident sleeping rooms. The total census of the 3 buildings was 128 at the time of the survey. The Court Building #3 is divided into 6 smoke zones.	K 000		
K 325 SS=D	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility	K 325	1. No residents experienced negative	1/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	**12/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	**1417 BRACE ROAD** **CHERRY HILL, NJ 08034**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 325	Continued From page 3 documentation on 12/16/2024, 12/17/2024 and 12/18/2024 in the presence of the facility's U.S. FOIA (b)(6) , it was determined that the facility failed to ensure that Alcohol Based Hand Rub (ABHR) dispensers exceeding five (5) gallons in total located in a single smoke compartment were stored in a proper location. This deficient practice was observed in 1 of 3 buildings and was evidenced by the following: Observations on 12/17/2024 at approximately 1:10 PM in the presence of the U.S. FOIA (b)(6) revealed there were 61 cases containing six (6) one Liter containers (33.8 fluid ounces each container) of Alcohol Based Hand Rub in the Atrium Building #1, Resident room #308. A review of the label attached to each dispenser reads in part: " 1 L (33.8 fl. oz.). Active ingredient, Ethyl alcohol 80% w/w. Warnings: For external use only Flammable: Keep away from fire or flame. Keep out of reach of children." The facility did not store approximately 96 gallons of ABHR in a proper location. On 12/18/2024 at approximately 1:34 PM, the U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety survey exit. NJAC 8:39 - 31.2(e)	K 325	outcomes as a result of the deficient practice of excess storage of alcohol-based hand rub sanitizer within a single smoke compartment. On 12/18/2024, the excess supply was immediately discarded appropriately. 2. All residents have the potential to be affected by this deficient practice. Additional supply closets were audited and no issues were found. 3. On 12/18/2024, Maintenance and Housekeeping staff were educated by the regional Plant Operations Director on proper storage of Alcohol-based hand rub sanitizer. 4. Maintenance Director/Designee will audit single smoke compartments for alcohol-based hand rub sanitizer storage monthly for x3 months. Any concerning findings will be corrected immediately. The results of these audits will be reported to the monthly Quality Assurance Performance Improvement committee.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315280	A. Building 01 - ATRIUM B. Wing	1/22/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0325	Correction Completed 01/17/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/23/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO